South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics

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ABSTRACT

The election of a democratic, nonracial government in South Africa has moved the health needs of the majority of the population to center stage. In the search for precedents, health policymakers have turned to South Africa's pioneering of health centers and social medicine in the 1940s. This paper looks at the intellectual context in which these ideas were first developed; the particular political circumstances and relationships between doctors and the state in the late 1930s, which facilitated the establishment of health centers; the role that the health centers were intended to play in South Africa's wider postwar health plans; and the reasons for the centers' failure. Contrary to conventional wisdom, it argues that the failure of the health centers and the wider health plans predated the advent of the National Party to power in 1948, and resulted mainly from the marginalization of the centers as a low-cost option for the poor, which was itself a consequence of underfunding and the vested interests of local health authorities and private practitioners. (*Am J Public Health.* 1997;87:452–459)

Introduction

Early in 1994, in the run-up to South Africa's first nonracial democratic elections, the African National Congress published its *National Health Plan for South Africa.* In it, the congress roundly declared, "The foundation of the National Health System will be Community Health Centres providing comprehensive services including promotive, preventive, rehabilitative and curative care."[1] This central recommendation not only reflected contemporary World Health Organization (WHO) thinking, but also echoed the ideas of the National Health Services Commission report published in South Africa 50 years before and rediscovered by public health activists over the previous decade.[2] Progressive for its time, the report put South Africa into the forefront of social medicine in the 1940s and led Malcolm Macdonald at the Ministry of Health in London to exclaim, "This is a report that shows us what we should be doing!"[3]

The National Health Services Commission was appointed in 1942 under the chairmanship of Dr Henry Gluckman to look into South Africa's contemporary crisis in health and health care. Its brief was wide ranging: "to inquire into, report and advise upon the provision of an organized national health service in conformity with the modern conception of health which will ensure adequate mental, dental, nursing and hospital services for all the sections of the people of South Africa."[4] Its recommendations involved the total reorganization of South Africa's health care system, embodied in the establishment of a national health service that would reach all the people of South Africa and be paid for out of a graduated, universal health tax assessed as part of general taxation. Existing health structures were to be rationalized under a unified system of state control with local answerability. The aim was to establish an integrated curative, preventive, and promotive health service to escape from the existing high-cost private practice and largely urban hospital system, which had manifestly failed the majority of the populace.

Thus, early in its proceedings, the commission recognized "that hospitals were of only secondary importance as components of a national health scheme," and that a more adequate foundation for "a modern comprehensive health service" was to be achieved by the establishment of community-based health centers.[5] These centers were to be based on a model already pioneered by Sidney and Emily Kark at Pholela in Natal in the early 1940s, which the commission visited in the course of its deliberations. The break with the hospital system, the centrality of the health centers, and the focus on health education all put the commission's report ahead of the contemporary Beveridge Report,[6] which established the National Health Service in Britain, and it has been these aspects of social medicine in South Africa in the 1940s that have also attracted attention more recently among public health professionals in United States. Thus, in July 1993, under the heading of "Public Health Then and Now," three articles in this Journal paid tribute to the work of Sidney and Emily Kark and to the health center movement they established, and pointed to the

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lessons of the public health initiatives of the 1940s and 1950s for a postapartheid South Africa.[7] Published in the context of the demand for reform of the US health system, the articles also stressed the lessons that the Karks' pioneering endeavor hold for the United States.[8]

While these articles—many of them written by professionals who were initially inspired by the Karks—very appropriately focused on the couple's extraordinary work as pioneer exponents and practitioners of the health center idea, they failed to analyze, except in the most general terms, the intellectual context in which the Karks first developed their ideas; the particular political circumstances and relationships between doctors, the Department of Health, and the state in the late 1930s and 1940s, which made this experiment possible; or, finally and perhaps most importantly, the part that the health centers were intended to play in the wider scheme of South Africa's National Health Services Commission plans of 1945 and the reasons for their failure. It is with these aspects of the social medicine experiment in South Africa that this paper deals.

The Intellectual Context behind the Karks' Ideas

Crucial in all these respects was the role played by a small group of progressive doctors, some of them within the Department of Health and for a short time close to government decision making. It does not detract from the remarkable achievements of Sidney and Emily Kark to point out that their work may never have gotten off the ground in the first place without the support of key individuals in the Department of Health from the late 1930s, such as Eustace H. Cluver as secretary of health (1938 to 1940), Harry S. Gear (then deputy chief health officer, later an assistant director general of WHO), and George Gale (secretary of health and chief medical officer, 1946 to 1952, and dean of Durban Medical School, 1952 to 1955). Moreover, without the recommendations of the commission and the role played by Gluckman as minister of health, even the limited success these individuals achieved would have been impossible. Of these key actors, Harry Gear, whose idea of "health units" was based on the example of similar work being done by the Dutch in Java, and George Gale, whose early career was spent as a mission doctor in rural Natal, were probably the most important.

Whether or not Gale was "the brain behind the Gluckman report," as Sidney Kark has remarked,[9] at a time when the Karks' ideas were by no means accepted by the majority of medical practitioners or even by all members of the Department of Health, his constant vigilance and reasoned defense of the health centers were often decisive. Government records are replete with his frequent interventions on behalf of the health centers as well as of the Institute of Family and Community Health at Clairwood, headed by Kark, which was designed to train health workers for the centers and undertake research into social medicine. Moreover, it was Gale, as dean of the Natal Medical School, who ensured that the Institute of Family and Community Health was consolidated as part of the Department of Preventive Family and Community Medicine in the Faculty of Medicine at the University of Natal.

Much of the recent literature on doctors in South Africa has tended to emphasize their conservative, not to say reactionary, character. In the apartheid era, the Medical Association of South Africa had a particularly pusillanimous human rights record.[10] Randall Packard has shown how, further back in time, physicians consistently placed the interests of employers over the health needs of African workers. Although he partially excepts public health doctors in the 1940s from his most severe strictures, Packard maintains that even these doctors failed to understand the real "structural contradictions in the development of racial capitalism in South Africa," which were producing the high rates of tuberculosis among Africans. He argues that what he terms their "environmentalist discourse" paved the way for "apartheid medicine," and that despite their awareness of the social causes of disease, they continued to advocate a purely medical response while the social policies they saw as necessary for improvement were left unimplemented.[11]

While Packard's views of the profession are broadly accurate, they fail to take into account the complexity of the ideas of the social medicine advocates in these years or their shifts over time. Through the health center movement these advocates, albeit small in number, were to contribute to some of the most notable developments in social medicine anywhere in the world. Gear, Gale, and Kark all worked later for WHO, and their ideas contributed to the development of international models of community health care. Despite undoubted ambiguities in their thought, leading figures such as the Karks, Gluckman, Gear, and Gale manifestly eschewed any simple environmentalist discourse. As the commission report makes clear, they explicitly identified both the sociopolitical causes of ill health and the sociopolitical means of preventing and curing it, even if, as Packard correctly suggests, they were ultimately powerless to implement the broader policies they believed necessary.

Nor was their notion of health care restricted to a "medical model." Unlike hospitals, clinics, or private practitioners, health centers were to have promotive (or educational), preventive, and curative functions, and were to be responsible for the total health care of both the individual and the community. Health assistants, whose role was primarily educative, were seen as the key health workers, and assessing community health needs was essential to their work. This was not simply a top-down affair: through leading group discussions and undertaking home visits and surveys, health assistants were directed to explore both what local health care workers considered the community's medical problems and "what the community feels, thinks and does about its health needs." Moreover, the program was to be "directed mainly towards those aspects about which people can do much themselves. . . . [T]he community's etiological concepts constitute an intrinsic element of the programme because ultimately it is their concept which provides the motivation for action."[12]

To understand the innovativeness of social medicine in South Africa at this time, it is also necessary to look at the wider social and health context. Through the 1930s there had been a mounting tide of concern with the problems of African health in both the town and countryside as South Africa's cheap labor policies based on migrant labor and rural impoverishment took their toll in escalating tuberculosis rates, malnutrition, and venereal disease. As health officials were not loath to point out, this had a direct effect on White health and wealth: not only, to use the cliche of the day, did "infectious disease know no color bar," but also the high morbidity and mortality rates were a drag on the economy at a time when secondary industry was rapidly becoming the most important sector of the economy and the mining industry was concerned about the physical reproduction of the labor force it had done so much to debilitate.[13] The rising number of Africans

in urban hospitals was the visible tip of the iceberg—and one that increasingly worried provincial authorities responsible for hospital services and reluctant to pay the cost.

Thus, in the hope that they would be able to provide cheaper rural health services for the Africans who were coming to the hospitals in increasing numbers, the then secretary of health, Eustace Cluver, decided to set up three rural health units and invited Sidney and Emily Kark to establish one such center at Pholela (as it happened, only one other health center got off the ground at this time because of the war). As Cluver announced early in 1939:

> In order to control expenditure on Native hospitalisation and to reduce the demand in a manner which will ultimately result in a considerable saving . . . a scheme has been evolved to establish inexpensive clinics for the early treatment of disease among Natives.[14]

Cluver was genuinely concerned with the rising tide of ill health among the African population and doubtless couched his letter in terms calculated to appeal to the Treasury, but as this text and others demonstrate, the main concern for many in the department, as it was for the provincial authorities, was the cost of African hospitalization. This concern lay behind their support for the establishment of health centers, which were seen as "inexpensive clinics." The publication in 1938 of a pamphlet titled "A Suggested Approach to the Health Needs of the Native Rural Areas of South Africa" provided some of the thinking from which the department's advocacy of rural clinics was to emerge. Written by George Gale, who at that time was working as medical officer of health in Benoni, the pamphlet was based on Gale's earlier experience as a mission doctor in rural Natal.

It was the intersection of these mundane considerations and Gale's pamphlet with the very different tradition out of which Sidney Kark was emerging in the 1930s at the University of Witwatersrand Medical School that sparked the creativity of the health center movement. Although one should not exaggerate the radicalism of the Wits Medical School, under the deanship of Raymond Dart it did encourage a more liberal engagement with African health issues. It was there, for example, that the young Dr Henry Gluckman lectured before he stood for parliament, a move dictated by his belief that the best way to improve the nation's health was through politics. It was there that such pioneers of nutritional studies as Theodore and Joe Gillman were at work. And it was there, in the left wing of the Labour Party, that the Karks met Dr David Landau, another pioneer of the social medicine movement and supporter of the health centers, who died at the tragically young age of 42.[15]

The Political Context of the Health Center Movement

Medical discourse at the university, like that in other fields, was influenced by developments in metropolitan thinking in the interwar years and, in particular, by the growing movement for social medicine that followed the publication of the Dawson report in the United Kingdom.[16] And while the social medicine of those years may prompt a later, more disillusioned generation to read into it an increase in the state's "disciplinary" powers and more subtle modes of medical control through screening and surveillance, there was also within it a liberating potential that inspired and excited the younger, more radical members of the medical community, surrounded as they were by the disease consequences of rapid industrialization and rural impoverishment.[17] In fact, nowhere was social medicine to receive more enthusiastic support, as the student reception of Henry Sigerist demonstrated; "prolific author, . . . defender of Social medicine, and . . . self-consciously irreverent gadfly of the American medical establishment,"[18] Sigerist was a guest of the South African Students' Visiting Lecturers' Trust Fund in 1939, his visit both a sign of the ferment of the times and a further stimulant to student radicalism.[19]

The war years saw a further and more general radicalization of the medical profession in South Africa, although it was a radicalization tempered with self-interest. The crisis in Black health in the 1930s had been paralleled by a crisis in White health, which was the product of land loss and of the transformation in the first decades of the century of large numbers of Afrikaners into an unskilled, urban workforce. In the early 1930s, one in five Afrikaners was classified as "poor White," and they too suffered much preventable ill health. Many had little access to health care, which they could not afford. There was a clamor against the high cost of medical care, and to the consternation of the profession, Afrikaners were believed to be turning in large numbers to forms of alternative medicine.[20]

Inspired partly by these concerns and partly by the idealism of the war years, the Federal Council of the Medical Association of South Africa set up a planning committee in April 1941 to consider a future national health policy for the Union. The *South African Medical Journal* carried a series of articles on the subject through 1941 to 1942 and published a pamphlet titled "Planning for Health in South Africa," which advocated a national health service controlled by medical practitioners. In the eyes of one rather hostile official in the Department of Health, however, this was nothing more than a "proposal that the health services of the country be handed over 'lock, stock and barrel' to the medical profession." Somewhat ironically, it was largely in response to this perceived threat from the profession that the government finally agreed to set up the National Health Services Commission.[21]

As a civil servant, Gale was not a member of the commission, but as Gluckman's confidant and adviser, he greatly influenced its outcome; according to Mrs Audrey Gale and the Karks, Gale spent hours with Dr Landau establishing "the foundations of the health service."[22] It was through Gale that Kark and Gluckman met, and Gale brought Kark's work at Pholela to the attention of the Gluckman commission. On leaving Pholela, Gluckman is said to have remarked, "This is the model for the native territories." By then, however, Gale, who had started out with a concern for the health needs of rural Africans, saw the health centers as a model not simply for the "native territories, but also for the whole country."[23] He was aware, as later scholars have been, that "change in the health care system cannot develop out of a program solely limited to the poor," because once it becomes simply a project for the poor and powerless, it can be dismantled far more readily.[24]

The Intended Role and Ultimate Failure of the Health Centers

Between 1946 and 1948, 44 health centers—a tenth of those originally planned by the commission—were established in both rural and urban areas in South Africa. Each health center served a defined area within which staff conducted home visits, and each provided a casualty

service for people living beyond who came of their own volition. The center staff also helped local people to provide "simple environmental sanitation" and stimulated the establishment of school feeding schemes, nursery schools, recreation clubs, gardening clubs, and discussion groups. Central to the entire Pholela scheme was the development of a circumscribed area within which reliable statistics could be collected so that improvements in mortality, morbidity, and living conditions could be measured and the outcome of a program of health education, carried out over a number of years, could be assessed. This epidemiologic approach, which was particularly necessary in the absence of any national registry of Black births and deaths, was now applied to the health center scheme as a whole. And through the keeping of accurate records, this strategy could also be shown to be cost-effective "despite criticism of it as the luxurious fad of mere doctrinaires."[25]

For the National Health Services Commission, too, the health centers were not an end in themselves. Ultimately the aim was to have a health center for every 25 000 people, each center with between six and eight doctors, in addition to nurses and other auxiliaries. These centers were intended to form part of a far wider vision: to be "the foundation of a truly comprehensive national health service" and "the first step in the implementation of . . . [the Commission's] recommendations . . . which also involved the nationalisation of all personal health services, in order to effect a more rational and efficient distribution of doctors and other health personnel."[26]

Lack of Political Will

Unfortunately, however, because other health services were not nationalized when the health centers were established, the health centers, which were intended, as Gale remarked, as "only a first step in the establishment of a national health service, . . . proved also to be the last."[27] And they soon came under fire. After 1948, when the Afrikaner National Party came into power, no further health centers were opened. This was despite Pholela's proven success in dramatically improving infant mortality rates and combatting infectious disease,[28] and despite numerous appeals, especially from African communities, for the extension of health centers to their areas. The bitter anticommunism of the Nationalists, which was strengthened by the cold war, further heightened the hostility to notions of social medicine with its connotations of "socialized medicine." The health centers were under constant scrutiny, and Clairwood, which always seemed to have attracted more flak, was completely dismantled in the mid-1950s when it was decided that the Department of Education would assume responsibility for the training of health workers. Most of the health centers were transferred to the provincial authorities and converted into "detached outpatient clinics." By the late 1950s, harassed by the state and finding themselves in an increasingly hostile political climate, many of the leading advocates of the social medicine movement had scattered, mostly to the United States and Israel. By then it was clear that a handful of underfunded health centers could not transform the country's health services.

The conventional wisdom, stressed by Gale himself and Kark and restated in the July 1993 *American Journal of Public Health,* is that all this resulted from the National Party victory in the 1948 elections. Thus, according to Gale, the health centers were "ultimately undermined by political action": "Having been introduced by one Government, they were looked at askance by the government which displaced it." As he bluntly put it:

> They offended particularly in their reliance on health education as the principal method for bringing about changes which would promote good health and prevent ill health. The practice of health education implies a belief in the democratic process and the Socratic method. This gave way to the belief that the non-Europeans who constituted 90 per cent of the clientele of health centres, would just do what they are told, without any dialogue.[29]

However, while the hostility of the National Party to the health centers and any provision for African welfare is undisputed, this was not the only, or perhaps even the main, reason for their failure, and the destruction of the health centers was not solely the Nationalists' responsibility. Long before the National Party came to power, the South African government had surrendered two "fundamental" aspects of the commission's vision: "that *all* health services be administered by the same authority" and "that *all* health services be paid for from taxation."[30] Regarding the first aspect, even before its report was published, Field Marshal Smuts, then prime minister, had given way to the clamor of the politically powerful provincial authorities, who were then responsible for running curative services, and allowed hospital services to remain in their hands despite the recommendations of the commission that these services come directly under the Department of Health.[31] According to Gale, the failure to bring all publicly funded health services under unified administrative control resulted in "incoordination, overlap and unbalanced development of services. Not only is the community broken into fragments for the purpose of personal health services,[11] he remarked, "but individuals are also fragmented."[32]

Regarding the second aspect, the electoral unpopularity of increased taxation made a direct health tax also too radical a recommendation for a beleaguered wartime government. Ironically, however, in 1945 the government did agree to refund 50% of provincial expenditure without restraints on its disbursement, and the provinces used the subsidy to pay for free hospitalization. As Gale pointed out in 1950, this meant that the Union government was "saddled with heavy commitments in support of services based on a principle which it . . . rejected in respect of its own services."[33]

The result of this lack of political will was that, from the outset, the health centers were starved for funds in favor of the hospitals. Although Gale did his best to defend and expand the health center movement, he was always short of resources, and expenditures on the health centers were always inadequate. In 1944/45, the vote was £50 000 (out of a total publicly funded state health budget of £1 300 000); by 1948 this had risen to £140 000, still less than 3% of the total vote for the Health and Mental Hospitals expenditure.[34] More than 50% of health expenditures at the time was private so that, even under the United Party government, the health centers received less than 1.5% of total government health expenditures. And it was, of course, a vicious cycle: the neglect of preventive and early curative health services led to an urgent demand for hospital beds from a growing number of desperately ill patients and so health costs continued to escalate.

Moreover, as the idealism and political militancy of the war years waned, most of the medical profession became bitterly hostile to notions of social medicine. District surgeons, appointed by the Department of Health to carry out public health functions in the rural areas and to care for the indigent, felt threatened and believed that the health centers had been foisted on them.[35] Like private practitioners, they feared the possible encroach-

ment on their practice by new-fangled health centers.[36] The "very happy conjunction of circumstances that there were on the Commission men very receptive to progressive ideas, and at the same time spokesmen for the organised profession who furnished them with progressive ideas and powerful arguments in support of them" had proved remarkably ephemeral.[37]

In response to their criticisms and to minimize both the "competition" with private practitioners and the overlap of function with local authorities who were responsible for preventive services, the health centers were now located only "in areas where local authorities were either non-existent or too poor to provide personal health services," or where the patients were too poor to pay private practitioners for their health care, as Gluckman took care to emphasize in addressing the South African Medical Congress in Durban in 1946.[38] Thus, personal curative care remained in the hands of private practitioners except—as in the past—for the indigent. And all this meant that, contrary to the original intention, the health center idea was becoming increasingly confined to the poor.

Far from reducing the vulnerability of the scheme, this served to marginalize it, for without powerful allies it was easier for the health centers to be starved for funds. This in turn was a direct result of the failure to create a *national* health service based on centrally provided funding. Under pressure from the doctors and on the insistence of the South African Medical Association, another principle was conceded by the early 1950s, when means testing was adopted for curative aspects of health center practice.[39] Yet as Gale remarked, devising a means test that was both "equitable and practicable" was far from straightforward, especially as the distinctions between indigent and nonindigent patients and between curative and preventive health care were by no means as self-evident as this "solution" implied: indigent patients were usually defined as those who "could not afford to pay" a private practitioner, but the decision seemed to be based on rule of thumb, given that patients could become indigent as a result of their illness, through consequent unemployment, or because they had to pay medical costs.[40]

The nonracial vision of the commission was also undermined by this shift to locating health centers among the poor. Thus, while in 1947 to 1948 the "poor" still included the White poor, by 1952 the Standing Committee of the commission (established to advise the minister on health matters in terms of the 1945 report) resolved, in what in some ways looked like a very progressive resolution, that "all personal health services *for non-Europeans* now conducted by local authorities be re-organised on the Health Centre basis." Part of the justification for this was "the proved necessity for the conduct of all medical and nursing services for non-Europeans [to be] *with the preventive outlook foremost*" (their itals), especially as "lower income groups" were most in need of health education. Thus, the resolution ended, "The Standing Committee feels convinced that the time has arrived for the official acceptance of the health centre as the means for improving the health of the non-European population *and reducing the costs of medical care*" (my italics).[41]

In policy terms, the racial distinction was new, but in practice by this time the vast majority of health centers were in Black areas. The "official acceptance" reflected the changed political climate, as the Nationalists began to implement far more rigorous racial segregation, which they termed *apartheid,* in all spheres of social life. The resolution was also evidence of the improved health of poorer Whites, which had resulted more from the economic boom of the early 1950s and National Party policies of protecting their White supporters than from any specific health intervention. Health centers were finally reduced back to being a cheap option for Black health care.

Internal Weaknesses

Less fundamental than the political considerations, perhaps, but nonetheless still significant, were administrative weaknesses in the early days, which may have yielded certain hostages to fortune. Initially, opponents of the scheme were able to make headway because the scheme had to be introduced before the necessary health workers had been trained and before the Public Service Commission had released the necessary funds. In April-May of 1947, David Landau, then chief of the Division of Social Medicine of the Department of Health in Natal and an enthusiastic exponent of the scheme, visited all the health centers in operation. He found it "a most depressing tour"; "seldom have I felt so low in spirit," he confessed. Everywhere he "encountered doubts" from both the department's officers and "informed outsiders" as to "the ability of our health centre scheme to function satisfactorily." More importantly, he shared these doubts. Only at Pholela, Springfield, and at one other of the health centers he visited was "work of good quality" being done; at five others, the work was "of poorer quality but still recognisable as the type of work which a health centre is required by definition to carry out."[42]

In the remaining centers was a variety of defects. Medical officers everywhere were "without exception unhappy" because they had no security of tenure and were working on contract for inadequate salaries, a reflection of the scheme's chronic underfunding. These officers were paid less than district surgeons or doctors in the provincial hospitals, and there seemed to be little prospect of improvement.[43] Low salaries, together with delays in the scheme's implementation and in the administrative response to applications for appointment, added to the profession's prejudice against the scheme. "So serious is the position, *vis-à-vis* opinion among medical men," Gluckman wrote, "that few, if any, applications would now be received were it not for the persistent personal efforts . . . made by members of the Advisory Committee and of the department, who have to apologise and explain away delays which to the applicants appear indefensible."[44]

As a result, many good people were already leaving the service, and many of those who remained behind were not of the right caliber and did not understand the principles of social medicine. Clearly not all the health center doctors were of the quality of Emily and Sidney Kark. The most successful centers then and later seem to have been those run by husband-and-wife teams, perhaps because of the sense of mission needed and the isolation of many rural settings. The husband-and-wife team was part of deliberate health center policy because of the nature of the "family" work involved. The notion that women doctors were better suited to family practice may have conformed to the conventional wisdom of the time; more unusual was the fact that women doctors were engaged at equal rates of pay (although they had no security of contract).[45] But the successful centers may have been fewer than the subsequent literature leads one to believe; that literature has after all been written by the handful of doctors who succeeded and were thus inspired by the experiment, rather than by the many who did not succeed.[46]

In his report Landau also noted other causes of discontent. The shortage of clerical staff in the department meant that doctors' letters seeking guidance or registering complaints were not answered, so the doctors felt isolated and demoralized while their staff, whether clerks, nurses, or health assistants, remained inadequate and untrained. Training was ad hoc and, especially with regard to nonmedical personnel, of dubious value. Premises were extremely difficult to acquire and often unsuitable, and there were real difficulties in the way of hospitalization and specialist services: many of the provincial hospitals were openly hostile. Landau concluded his gloomy report by questioning the wisdom of establishing large numbers of health centers and suggested rather that

> our major efforts should be bent towards establishing and equipping with suitable personnel a few good health centres by which we may not be ashamed to be judged, rather than setting up under the name of health centres institutions of indifferent character, giving a service, little if at all better, than that obtainable in the crowded rooms of an overburdened polyclinic or out-patient department.[47]

These may have been teething problems but they continued well into 1949, giving the health center critics their ammunition and undermining the attempts of more progressive members of the department to protect the centers.[48]

The commission had recommended that a special Health Services Advisory Committee should determine conditions of service for health center personnel, but this did not happen. As a result, as Gale corroborated in 1949, "the conditions of service of medical officers at Health Centres [were] less favourable than in any other branch of the public service."[49] Two years later, he was to confess that his department was "completely frustrated in its endeavours to secure higher salaries" for workers in the health centers.[50]

In the 1940s the Karks, Gale, and Gluckman had been able to make use of a rare window of opportunity to initiate and develop farsighted policies of social medicine. That window was in part the result of the war and the brief period of reformism that resulted, and in part the coincidence of a crisis in Black health, which seemed to be resolvable more cheaply for White taxpayers and provincial authorities through health centers than through hospitals, with a crisis in White health, which momentarily lent the health center idea wider support through the report of the commission. The wartime expansion of the economy and, after 1948, the economic policies of the National Party that protected poor Whites in the marketplace, together with the provision of free hospital services, removed the urgency for reform among Whites[51]; at the same time, the balance of forces in the state shifted so that the influence of the handful of liberals in the Department of Health disappeared, taking along with it the impetus behind social medicine that came from within the department.

This happened well before the Nationalists took power although the attack on health centers undoubtedly intensified thereafter. Enemies of the scheme were able to use weaknesses in its implementation to undermine the health center movement, while the conservatism of the medical profession reasserted itself after the war to subvert the movement. By 1950 the opposition was coming from within the department, where Dr H.F. Anecke, who was acting chief medical officer in Gale's absence overseas, used the opportunity to appoint a highly critical committee of enquiry into the Institute for Family and Community Health and the very principle of the health centers.[52] With the dispersal of many of the doctors most dedicated to the health centers, the social medicine movement died in South Africa—even as these ideas spread to Israel, the United States, and Asia[53]—until the reformism in the 1980s and the advent of a postapartheid government in 1994.

Conclusion

Given the priorities of the Nationalist government after 1948, it is perhaps not surprising that it was hostile to the recommendations of the National Health Services Commission for a universal health service. What is important to note here is that the commission's central ideas of national service based on notions of the health centers were dropped even before 1948. As Marks and Andersson have pointed out, the central dictum of the commission—that "unless there were drastic reforms in the sphere of nutrition, housing, health education and recreation, the mere provision of more doctoring would not bring more health to the people of the country"—demanded a drastic restructuring of the social order, which went well beyond the White consensus and perhaps exceeded the capacity of the political economy, which was still heavily dependent on the low-wage sectors of farming and mining.[54] Dominant Whites were not prepared to sustain the costs involved in a National Health Service once "poor Whites" had largely disappeared, and health centers reverted to being "inexpensive clinics for the early treatment of disease among Natives."[55]

The result was the continued neglect of preventive medicine and health education, continued high levels of infant mortality from malnutrition and infectious disease, and inordinately high rates of diseases of poverty such as tuberculosis. The advocates of social medicine in the 1940s would have found the health picture confronting South Africa's new government in the 1990s depressingly familiar—and the government's policy prescriptions perhaps refreshingly so. They may also have had some words of warning for contemporary health planners on the dangers of failure to provide for universal and unified health services; on the need to win over the medical and nursing professions to their major transformation; on the necessity for the adequate resourcing of primary health care; on the importance of appropriate training of health workers accountable to and in tune with their communities; and, most importantly, on the limitations of health programs that are directed only at the poor and operate in isolation from broader sociopolitical and economic measures to transform the health of the people. As the commission remarked, "the mere provision of more doctoring" is not enough.

As in the 1940s, so in the 1990s: failure to implement a comprehensive and inclusive national health service based on the integration of preventive, promotive, and curative health may marginalize primary health care as a second-class service for second-class citizens even in the new South Africa. And while primary health care based on health centers may be the foundation of a health service, like "mere doctoring" it may not be enough without real economic redistribution. □

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2. See, for example, Cedric de Beer, *The South African Disease: Apartheid Health and Health Services* Yeoville (South Africa: Southern African Research Services, 1984), 15–30.
3. For the quotation, see P.V. Tobias, "Henry Gluckman," *South African Medical Journal* 72, (August 1987):303. I am grateful to Professor Tobias for a copy of this obituary and for sharing his thoughts with me in an interview in 1988. For South African social medicine's international standing, see, for

example, George W. Gale, "Health Services in Three Continents," in the George Gale Papers (currently in temporary possession of the author), 1950. In 1946, for example, the Indian Commission on a national health service seems to have drawn on the National Health Services Commission report for its conception of a comprehensive system (Gale Papers, Gale to "My dear Eustace [Cluver]," October 8, 1967), and in Australia, public health doctors were also looking to the South African experience (Linda Bryder, personal communication, August 1996). This paper has been largely based on the Department of Health files in the South Africa State Archives in Pretoria, on the George Gale Papers, and on the Gluckman Papers in the manuscript collection, University of Witwatersrand library.

4. U.G. No. 30-1944, Union of South Africa, *Report of the National Health Services Commission on The Provision of an Organized National Health Service for all sections of the People of the Union of South Africa, 1942–1944* (Pretoria: Government Printer, 1944), 1.
5. George W. Gale, "The Aftermath: The 'Gluckman' Report—An Abiding Value," in Henry Gluckman, *Abiding Values: Speeches and Addresses* (Johannesburg, South Africa: Caxton Ltd, 1970), 497.
6. *Beveridge Report* (London: Her Majesty's Stationery Office, 1942). For the Beveridge Report, see Charles Webster, *The Health Services Since the War. Volume I: The Problems of Health Care and the National Health Service Before 1957* (Her Majesty's Stationery Office, London, 1988), 34–43.
7. Harry T. Phillips, "The 1945 Gluckman Report and the Establishment of South Africa's Health Centers," 1037–1039; Mervyn Susser, "A South African Odyssey in Community Health: A memoir of the Impact of the Teachings of Sidney Kark," 1039–1042; and Derek Yach and Steve M Tollman, "Public Health Initiatives in South Africa in the 1940s and 1950s: Lessons for a Post-Apartheid Era," 1043–1050, *American Journal of Public Health,* 83 (July 1993).
8. H. Jack Geiger, "Community-Oriented Primary Care: The Legacy of Sidney Kark," *American Journal of Public Health* 83 (July 1993):946–947.
9. Interview with Sidney and Emily Kark, Jerusalem, September 29, 1982. I am immensely grateful to the Karks for many friendly conversations about health centers and about health matters more generally over the years since then.
10. The full extent of this is only now coming to light in the hearings before the Truth and Reconciliation Commission. See, for example, *Apartheid Medicine, Health and Human Rights in South Africa: Report of a Medical Mission of Enquiry . . . April, 1989* (Washington, D.C.: American Association for the Advancement of Science, 1990).
11. Randall M. Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley, Calif.: University of California Press, 1989), 215, 235–247.
12. George W. Gale, "The Training of Health Assistants as Health Educators," c. 1951 in the Gale Papers.
13. Shula Marks and Neil Andersson, "Industrialization, Rural Health and the 1944 National Health Services Commission in South Africa," in *The Social Basis of Health and Healing in Africa,* ed. Steven Feierman and John M. Janzen (Berkeley, Calif.: University of California Press, 1992), 142–144.
14. Cf. "Native Health and Hospital Services. Notes of a subcommittee of Provincial Consultative Committee held in Pretoria on 7th November, 1938," in Department of Health Files (henceforth, Gesond Files), 155 1/62, South African State Archives, Pretoria. The quotation is from an enclosed letter dated February 4, 1939.
15. Kark interview.
16. The full title of the Dawson report is *Interim Report on the Future Provision of Medical and Allied Services* Cmd. 693 (Her Majesty's Stationery Office, London, 1920). For social medicine in Britain in the interwar years, see J. Lewis, *What Price Community Medicine* (Brighton, England: Wheatsheaf, 1986); Dorothy Porter, "Changing Disciplines: John Ryle and the Making of Social Medicine in Britain in the 1940s," *History of Science* 30 (1992): 137–164; and Dorothy Porter, "John Ryle: Doctor of Revolution," in *Doctors, Politics and Society: Historical Essays* ed. D. Porter and R. Porter (Amsterdam, the Netherlands: Rodopi, 1993), 247–274.
17. The increase in community surveillance through social medicine and its ancillary, the social survey, is the central burden of David Armstrong's critique in *The Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (Cambridge, England: Cambridge University Press, 1983), esp. 32–41. These ideas are, of course, drawn from the work of Michel Foucault, especially his *Discipline and Punish: The Birth of the Prison* (Harmondsworth, England: Penguin, 1991) and *The Birth of the Clinic* (London, England: Tavistock, 1976). I hope to discuss these issues further in a forthcoming article on "George Gale, Social Medicine and the State in South Africa."
18. Charles Rosenberg, *Explaining Epidemics: And Other Studies in the History of Medicine* (Cambridge, England: Cambridge University Press, 1992), 261. For Henry Sigerist, see also Elizabeth Fee and Edward T. Morman, "Doing History, Making Revolution: The Aspirations of Henry E. Sigerist and George Rosen," in *Doctors, Politics and Society,* 275–311.
19. Kark to Gale (in response to a request for information from Gale for his paper for *Abiding Values,* September 20, 1967), no address or date, Gale Papers, Airletter card no. 2, p. 1. (This is the continuation of a longer letter, but unfortunately, the first airletter card is missing.)
20. Marks and Andersson, "Industrialization, Rural Health," 152–155.
21. See *South African Medical Journals* (1941 and 1942) and Medical Association of South Africa, *Planning for Health in South Africa* (Johannesburg: Medical Association of South Africa [pamphlet], December 1941 or January 1942). The minute is in "Dr. Gluckman's Motion—Order no. 1, House of Assembly, 17th February 1942," in Gesond Files, 1756 2/95/33. This was Gluckman's second attempt, and there had been a number of previous unsuccessful attempts. See Marks and Andersson, "Industrialization, Rural Health," 154–155.
22. Kark interview; author's interview with Mrs. Audrey Gale (Gale's widow), June 21, 1983. On the other hand, Dr. C.J. Albertyn was probably responsible for drafting the health center section of the report; see "Confidential. Report on a Meeting of the Secretary for Health and Dr. C.J. Albertyn, member of the Health Centres Advisory Committee, with staff of the Training Scheme and Medical Officers in training on 6th and 7th January, 1947, at Springfield." In the Gale Papers.
23. Ibid.
24. Yach and Tollman, "Public Health Initiatives in South Africa," 1047. For a similar perception based on the analysis of welfare reform in Europe, see Peter Baldwin, *The Politics of Social Solidarity: Class Bases of the European Welfare State 1875–1975* (Cambridge, England: Cambridge University Press, 1990), 292.
25. "Health Centres in South Africa: An Obituary," part of a manuscript found in the Gluckman Papers, A1207 B2.2, University of Witwatersrand.
26. Ibid.
27. Ibid.
28. For the success of Pholela in reducing infant and general mortality rates, see Sidney Kark and G. Steuart, eds. *A Practice of Social Medicine. A South African Team's Experience in Different African Communities* (Edinburgh, Scotland: Livingstone, 1962). According to Gale "Health Services in Three Continents," 32, the general death rate was reduced by a half and infant mortality, by two thirds in 5 years.
29. "An Obituary."
30. Gale, "Health Services in Three Continents," 24.
31. The powers of the provinces had been safeguarded by South Africa's Act of Union, but Smuts's concession may have reflected the weakness of a wartime government governing a divided population rather than the absolute strength of the provinces in relation to central government.
32. Gale, "Health Services in Three Continents," 31.
33. Ibid., 25.
34. Memo to The Honorable the Minister: "Standing Committee of the National Health Council," signed G.W. Gale, August 17, 1948, in Gesond Files, 2746 65/70A C.T.66 Copy JH.
35. By the 1940s, district surgeons provided curative services for the indigent mainly in the rural areas, but the system had "in . . . practice . . . broken down, largely because of lack of funds." The surgeons also carried out official and public health work for the central government and for local authorities without their own ministries of health. Most of these surgeons had private practices, and this created a conflict of loyalties (see *National Health Services Commission*

report, vol. 113, paragraphs 138–146, 57–58).

36. For the medical hostility, see, for example, the intemperate attack in the letter by Dr. Rogaly and three others to Dr. Kark, August 11, 1949, in Gesond Files, 2745; see also "Government Health Centre Services," letter to the medical secretary from the secretary for health, January 30, 1948, in the Gluckman Papers, A1207 B2.2 (typescript copy, marked Item 4 (c) "Strictly confidential"), which addresses similar complaints about the loss of income from a Dr. Gordon in Thaba 'Nchu.
37. The phrase is Gale's in Gale to "My dear Eustace."
38. "An obituary"; text of an address delivered November 9, 1946, in Gluckman, *Abiding Values,* 478–491, quoted on 488.
39. Kark to Gale, January 18, 1951, in Gesond Files, 2745 65/70.
40. "Government Health Centres in the Union of South Africa," *South African Medical Journal* 23 (July 1949): 631.
41. "Extract from the minutes of the Twentieth Standing Committee of the National Health Council, held on July 3rd, 1952," Gluckman Papers, AD1207 B2.1.
42. "Notes on the Health Centre Scheme," May 20, 1947, in Gesond Files 2727 1/70.
43. Ibid.
44. Gluckman to the chairman, Public Service Commission, February 14, 1946 (copy), in Gale Papers.
45. "The health centres service of the Ministry of Health," confidential, n.d., in Gluckman Papers, A 1207 B2.2.
46. See, for example, Gale, "The 'Gluckman' Report," and the *American Journal of Public Health* 83 (July 1993): 1037–1050.
47. David Landau, "Notes on the Health Centre Scheme," May 20, 1947, in Gesond File 2727 1/70.
48. Cf. N. Reeler, Undersecretary to Secretary Health (Gale) September 6, 1949, warning against any expansion of health center work: "The Department is hard put to it, at present, to find personnel for 'outside' health centres. A large number of health centres still await opening and personnel are being refused leave on account of lack of relief. Candidly I am extremely worried about the work which is being carried out at outside health centres." In Gesond File 2745 65/70.
49. Gale, "Government Health Centres," 632.
50. Gale to Honorable Minister (Bremer) November 7, 1951, "The functions of the IFCH [Institute of Family and Community Health] (Clairwood) with particular reference to the Durban Medical School." In Gesond Files, 2746 65/70A.
51. In the Orange Free State, there was a means test, but probably 90% of the population qualified for free hospitalization. Theoretically, Africans were also eligible for free hospital treatment, but the number of beds available for Africans even in the urban areas was always woefully inadequate, and in the rural areas Africans remained largely dependent on small, subsidized mission hospitals, which came under the Department of Health only in 1973.
52. Memo from Gale to Dr. K. Bremer, minister of health, March 1951, "The Committee on Health Centres," in Gale Papers. I have not yet managed to track down the proceedings of this committee, but both from Gale's response and according to the Kark interview, it was extremely hostile, and Dr. Kark threatened to sue the minister for defamation of character.
53. Although the *American Journal of Public Health* devoted its attention to the spread of the movement in the United States and Israel, Gale himself, as a World Health Organization consultant, took the idea to Uganda, Thailand, and Malaysia. I hope to research this aspect of the subject further. *National Health Services Commision Report,* p. 28. See also pp. 97, 102; Marks and Andersson, "Industrialization, rural change," 159.
55. See footnote 12.